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VIA ELECTRONIC MAIL
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Brenda Destro
Deputy Assistant Secretary
The Office of the Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Social Risk Factors and Medicare's Value-Based Purchasing Programs Request For Information

Dear Ms. Destro,

On behalf of the Adventist Health System (AHS), we appreciate the opportunity to comment on the Social Risk Factors and Medicare's Value-Based Purchasing Programs Request for Information (RFI) by the Assistant Secretary for Planning and Evaluation (ASPE). Our organization includes 46 hospital campuses located across nine states and comprises more than 8,200 licensed beds. AHS provides inpatient, outpatient and emergency room care for four million patient visits each year.

AHS applauds the efforts that the Department of Health and Human Services (HHS) is taking to study how social risk factors influence patient outcomes and hospitals' performance under value-based payment models. To ensure that hospitals are not unfairly penalized for serving vulnerable populations, we believe that it is important to address social risk factors and work collaboratively to achieve health equity. Not every community faces the same social risk factors, and some are limited in their ability to be healthy because they have fewer social and economic opportunities. For example, in the bottom performing counties in the nation, one out of five children do not graduate from high school in four years.[1] These social and economic factors can account for up to 40 percent of health outcomes, while clinical interventions only account for 20 percent.[2] Therefore, to improve the health of individuals, social risk factors must be addressed. Below are the responses to the questions posed in the Social Risk Factors and Medicare's Value-Based Purchasing Programs RFI.

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[1] County Health Rankings and Roadmaps. 2018 County Health Rankings Key Findings Report.
[2] County Health Rankings and Roadmaps. What is Health?

Responses to the RFI

Are social risk data being used to target services or provide outreach? If so, how?

In the discharge planning process, Care Managers collect social risk data—such as living situation, emotional factors and environmental barriers—on each patient. This data is also collected in the outpatient setting at physician practices and emergency departments. Based on the information collected, interventions are made when social needs are identified. The method and social risk factors collected can vary across hospitals. Care Managers, supported by a multidisciplinary team (e.g. Clinical Social Workers, nurses) generally collect social risk data during the patient's discharge planning assessment, which happens within 48 hours of a patient being admitted to the hospital. The Care Manager then connects the patient with community partners that can address the identified social needs. Community partners can include Federally Qualified Health Clinics (FQHCs), churches, shelters or universities. For example, Adventist Health System has a transitional care program that coordinates care with local community partners to ensure that there is continuity of care for patients when transitioning from the hospital to their homes.

How are beneficiaries with social risk factors identified?

Patients with social risk factors are generally identified and supported through a discharge planning assessment, including a readmission risk evaluation, when they are received into the acute care hospital setting. The factors collected through these assessments vary across hospitals. Below is an example of the social risk factors collected by our AHS facilities.

- Age
- Gender
- Marital status
- Living Situation (e.g. Alone, Assisted Living Facility, Incarcerated, Homeless, Traveler, Lives with Friend, Domestic Violence Shelter)
- Support System (e.g. None, Friends, Organization, Church/Spiritual Life, Extended Family, Community, Cares for Self, Spouse/Family, Private Caregiver)
- Socio-economic History (e.g. Employed, Parent/Guardian is Employed, Spouse/Significant Other is Employed, Food Stamp Recipient, Women Infants and Children, Temporary Assistance for Needy Families, Unemployed)

- Environmental Barriers (e.g. No Barriers in Home, Inadequate Heating and Cooling, Lack of Transportation, No electricity in Home, No Running Water)
- Emotional Factors (e.g. Difficulty Managing Stress, Psych Consult Pending, Identified Psychiatric Diagnosis, Irritable/Agitated, Isolated/Lack of Social Interaction, Somatic Complaints/Chronic Fatigue)
- Major Stresses (e.g. Caring for Elderly Parent, Death in Family, Death of Spouse, Disability, Divorce, Marriage, Trauma, Unemployed, Work Problems, Homeless, Financial)
- Complex Needs (e.g. Domestic Violence in Family, Premature Infant, Behavioral Health Placements, Financial or Insurance Issues, Scarce Resources, Chemical Abuse)

What are promising strategies or best practices for improving care for patients with social risk?

The recognition of social risk factors and their impact on patient outcomes has spurred nationwide efforts to improve care for patients with social risk. Some promising strategies include social risk screenings, connecting patients with community resources, care navigation services and investments in community-based initiatives.

Social Risk Screenings

The push to address social determinants of health has led to an increase in the number of screening tools that have been developed to identify individuals with social risk factors.[3] The use of these tools are an emerging trend, as they can help health systems to identify patients that may need additional support. For example, a two-question screening tool developed by the U.S. Department of Agriculture can be used to determine whether an individual is food insecure.[4] This information, depending on the capability of the hospital's Electronic Health Record (EHR), can be documented in the patient's EHR to facilitate care coordination.

Connecting Patients with Community Resources

Once a patient's social risk factors are identified, a common best practice is for a Care Manager to connect the patient to community resources that meet such needs. This includes connecting patients with a

[3] Public Health Reviews. Screening for social determinants of health in clinical care: moving from the margins to the mainstream.
[4] American Academy of Pediatrics Publications. Promoting Food Security for All Children.

local clinic for primary care services or with Meals on Wheels and food banks for food assistance. Researchers at the Yale Global Health Leadership Institute found that partnerships that provide access to resources such as housing and nutrition programs improve health outcomes and lower health care costs among low-income and vulnerable populations.[5]

Care Navigation Services

Providing care navigation services is an emerging strategy to reduce barriers to care. This includes providing home visits, phone calls, prescription assistance, arranging for follow-up appointments and securing transportation to appointments for patients. Offering and providing this assistance to individuals with social risk factors is crucial to ensure that they are receiving needed resources and completing their medical treatment. Care navigation roles are generally occupied by a Care Manager or Social Worker.

Investments in Community-Based Initiatives

Many of our AHS hospitals have invested in community-based initiatives designed to ensure that patients with social risk factors receive the necessary resources to have healthy lives. For example, one of our member hospitals, Florida Hospital Orlando, provided a $6 million donation to the region's Housing First initiative to end chronic homelessness. This initiative has housed 555 individuals who were chronically homeless and housed another 168 people suffering from serious physical or mental illness, totaling 723 people. Housing the chronically homeless has helped saved the community millions of dollars in jail and police costs and has reduced their utilization of the emergency department by more than half.[6] Similarly, Adventist Health in California partnered with community stakeholders to develop "Project Restoration," an initiative to provide housing and intensive care management services to the homeless. This has resulted in average cost savings of over $5,000 per patient, per month. Community-based initiatives have proven to be effective in addressing social risk factors and improving clinical outcomes.

What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?

In order to successfully refer a beneficiary to a social service organization, AHS suggests that a best practice is to identify the social needs early. This can be done through the discharge planning assessment

[5] Yale Global Health Leadership Institute. Leveraging the Social Determinants of Health. What Works?
[6] Orlando Sentinel. Central Florida Leaders Mark Milestone in Housing Homeless.

at the point of a patient's entry to the hospital. As soon as the needs are identified, the Care Manager or Social Worker can connect the patient to community resources. Follow-up phone calls or visits are also recommended to ensure that the patient receives the needed assistance.

What are barriers to tailoring services to patients with social risk factors? How can those barriers be overcome?

There are many barriers that hospitals face when tailoring services to patients with social risk factors. These include:

- **The lack of access to health care services for behavioral health patients.** Since the deinstitutionalization of psychiatric services, there has been a growing shortage of psychiatric beds. Individuals that require intensive psychiatric care usually end up homeless or in prison.[7] A recent report by Merritt Hawkins found that around 13.6 million Americans live with a serious mental illness, but 60 percent received no mental health services in the past year.[8] Due to the shortage of behavioral health beds, hospitals often struggle to find behavioral health facilities and resources to connect patients in need after discharge. In addition to the lack of services, rehab centers or primary care providers sometimes refuse to take patients that have behavioral health issues for follow up services.

- **The lack of adequate community resources**. Finding enough resources to meet the needs of patients facing social risk factors is a major barrier to addressing those factors. AHS hospitals have taken part in several initiatives to address social risk factors for vulnerable populations. These initiatives include partnering with food pantries or helping to staff free clinics, but there remain situations where there are not enough resources. For example, one of AHS's member hospitals, Florida Hospital Orlando, contributed $6 million to the Housing First initiative in the City of Orlando which has helped 723 chronically homeless individuals receive housing.[9] Despite these efforts, there are still many individuals with disabilities and mental illness that are waiting to find housing.

[7] Health Affairs. The Changing Role of the State Psychiatric Hospital.
[8] Merritt Hawkins. The Silent Shortage.
[9] Orlando Sentinel. Central Florida Leaders Mark Milestone in Housing Homeless.

- **The higher costs associated with coordinating care for social risk patients.** The costs associated with tailoring services for social risk patients can be significant because these patients require more resources, such as wraparound services and transportation. While some hospitals may have the ability to invest in such resources adequately, others may find it more challenging. The lack of sufficient funding, coupled with scarce community resources, can make it difficult to tailor services for patients with social risk factors.

- **The lack of interoperability and lack of ability to document social risk factors in EHRs.** To address a patient's social needs, it is crucial to gain historical information that identifies referral needs and examine previous failures that resulted in a patient not being able to remain healthy outside of the hospital setting. Due to the lack of interoperability among EHRs, hospitals often find it difficult to access information regarding services or resources received by a patient outside of the hospital walls. This includes data sharing with other hospitals as well as with organizations providing social services. The inability to access such data hampers the ability of hospitals to coordinate care for patients with social risk. Additionally, the majority of EHRs do not support the documentation of social risk factors. While many of our member hospitals document social risk factors in the medical record, it is usually not in fields that would make it conducive to data collection. Epic is one of the few EHR companies that has tried to standardize social determinants of health data into the medical record.

- **The separation of substance use data from the medical record.** Currently, 42 CFR Part 2 requires a patient's Substance Use Disorder (SUD) records to be separated from the medical record. As a result, clinicians are often unaware of the behavioral health needs of an individual. This limits the ability of providers to coordinate care for patients with behavioral health issues and tailor services appropriately.

In order to address these barriers, AHS recommends that policymakers:

- Increase the community resources and services available for patients with social risk factors, particularly for those facing behavioral health issues.
- Increase the number of alternative payment models that account for the clinical and social needs of vulnerable populations.

- Engage in efforts to advance interoperability. This may include designating, through the Office of the National Coordinator for Health IT (ONC), an open Application Programming Interface (API).
- Incentivize the standardization of social risk data collection in EHR systems.
- Align 42 CFR Part 2, which governs the confidentiality of SUD patient records, with HIPAA.

What lessons have been learned about providing care for patients with social risk factors?

The greatest lesson is that the presence of social risk factors is a major contributor to patient noncompliance. For example, a patient facing diabetes or other comorbid conditions can easily be labeled as noncompliant if they are not following a prescribed diet. However, that patient may be faced with food insecurity and can only afford to buy cheap, processed foods. Literature has also found that social factors play a role in patients' noncompliance to treatment plans. One study found that 13 percent of Medicare patients reported cost-related noncompliance. This rose to 29 percent for disabled Medicare patients.[10] To ensure patients can comply with their treatment, hospitals must proactively identify a patient's social needs. Patients with social risk factors also experience difficulty navigating the health care system due to many issues, such as not having a permanent address or phone number. This makes it more difficult to track those patients and ensure that they are getting the services they need. Therefore, a major lesson is that even after connecting patients with clinical or social services, it is necessary to follow-up with the patient or health provider to ensure compliance.

How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)?

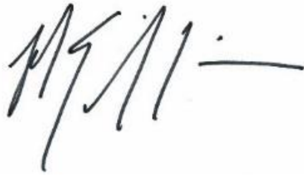
The costs for targeting and providing services to individuals with social risk factors vary across AHS hospitals. Hospitals generally have charity and care management budgets that contain dedicated funds for addressing issues such as transportation and medication costs. Facilities have additional staff, such as Care Navigators, Transitional Care Coordinators and outreach clinics, that help patients with social risk factors.

Conclusion

[10] PubMed. Cost-Related Medication Nonadherence Among Elderly and Disabled Medicare Beneficiaries.

AHS welcomes the opportunity to further discuss any of the recommendations provided above. If you have any questions or would like further information, please do not hesitate to contact Julie Zaiback-Aldinger, Director of Public Policy and Community Benefit, at Julie.Zaiback@AHSS.org.

Sincerely,



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